

INTERIM REPORT ON THE DAKOTA COUNTY MENTAL HEALTH COURT PROJECT

**Prepared by: Dakota County Community Services Planning
June 6, 2006**

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Introduction/Purpose

The purpose of this interim report is to provide an update on the status of progress toward implementing a Mental Health Court in Dakota County.

Charge

The Dakota County Board of Commissioners identified a 2005 strategic goal of improving services to offenders with mental illness by exploring the feasibility of establishing a specialty court. For 2006, the County Board established a goal of implementing the Court in 2007.

Participants

Throughout 2005 and 2006, a Workgroup of county staff from the Jail, Public Health, Social Services, and Community Corrections has been investigating a range of options for more efficiently, effectively, and humanely serving offenders with mental health concerns.

Table 1. Workgroup Participants

NAME	DEPARTMENT/DIVISION
Barbara Illsley	Community Corrections
Tim Cleveland	Community Corrections
Tina Isaac	Social Services
Bonnie Brueshoff	Public Health
Wendy Bauman	Public Health
BJ Bjorge	Sheriff (Law Enforcement Center)
Hal Palmer	Sheriff (Law Enforcement Center)

A Steering Committee has been guiding the overall direction of the project.

Table 2. Steering Committee Membership

NAME	DEPARTMENT/DIVISION
Barbara Illsley	Community Corrections
Tim Cleveland	Community Corrections
Jim Backstrom	County Attorney
Judge Edward Lynch	District Court
Don Gudmundson	Sheriff
Steve Holmgren	Public Defender

Community Services Planning (Joe Schur, Meghan Kelley Mohs) has provided staff support for this project.

Timeline/Work Completed to Date

A timeline was established for completing work toward implementation of a specialized criminal court for individuals with mental illness, many of whom also have co-occurring chemical health concerns. At this writing, work has been completed through step #4 as enumerated on the Table in Appendix A. Due to the imposition of a "soft" hiring freeze during 2006, and the resulting inability to hire new staff for the court, the project is temporarily on hold at this writing.

Specific tasks completed to date, include the following:

- Research on the prevalence of mental illness among the offender population and collection of data on offenders in Dakota County in order to help refine the target population.

- Research on specialty criminal courts, potential costs and benefits, and model options.
- Research on staff perspectives regarding possible service enhancements for this population.

The findings resulting from Workgroup effort relating to the above tasks are discussed in greater detail in the balance of this report

Prevalence of Mental Illness Among the Offender Population, Nationwide and Dakota County

Nationwide, the prevalence of mental illness among local jail and probation populations far exceeds that of the incidence in the general population. The Surgeon General found that 9 percent of Americans experience "significant impairment" as the result of mental illness, with 5.4% identified as "seriously mentally ill" and 2.6% as "seriously and persistently mentally ill."¹ In contrast, the federal Bureau of Justice Statistics reports that 16.3% of local jail inmates and 16.0% of probationers are mentally ill.²

There have been numerous attempts to identify the extent of mental health concerns among the Dakota County offender population. Most of these efforts have been led by Office of Planning, Evaluation, and Development (OPED) and have focused on the population at the Law Enforcement Center (LEC). Key findings include the following:

- 36% of all LEC inmates have a history of mental illness;
- 23% are treated with psychotropic medication while in jail.

Chemical health concerns are also common among this population. On the local level, past studies have shown 55% of all LEC inmates either being charged with a crime involving drugs or alcohol or reporting a current chemical health concern. Overall, chemical or mental health issues affect about two-thirds of the jail population, with nearly one-fifth (19%) evidencing both problems simultaneously.³

Less clear was how the offender population may have changed since these OPED studies were completed (2003), or how many offenders with mental health and/or co-occurring mental health and chemical health concerns were not being identified by the current processes in place at the LEC and in Community Corrections. In late 2005 and early 2006, the Workgroup initiated new research regarding detainees in the Dakota County LEC to further investigate two specific areas of inquiry:

1. The prevalence of likely mental illness among offenders at Jail booking through an enhanced screening process;
2. The characteristics of individuals already identified as mentally ill and receiving mental health services at the LEC.

¹ U.S. Department of Health and Human Services (1999). *Mental health: A report of the Surgeon General—Executive summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, Available on-line: <http://www.surgeongeneral.gov/library/mentalhealth/home.html>.

² Bureau of Justice Statistics (1999, July). *Special report: Mental health and treatment of inmates and probationers*. Washington, DC: US Department of Justice, Office of Justice Programs (Publication #NCJ 174463.), Available on-line: <http://www.ojp.usdoj.gov/bjs/pub/pdf/mhtip.pdf>. The Bureau of Justice Statistics defines *mental illness* as an inmate's self-report of the existence of a "mental or emotional condition," or self-report of having experienced an overnight stay in a mental hospital or program.

³ See OPED *Jail Snapshot (2003)*., Available from OPED. See also *Jail Population Study (2003, April 16)*., Available on-line at: <http://www.co.dakota.mn.us/oped/pdf/Jail%20Study/2003%20Jail%20Study.pdf>.

Results of Jail Mental Health Screening

Using a research-validated⁴ tool,⁵ between October 3, 2005 and January 31, 2006, the LEC completed 1329 mental health screenings of inmates at the time of booking. Several caveats are necessary when reporting the results of the aggregated data resulting from these screenings. Some inmates were booked multiple times (and therefore screened more than once) during this time period, a few screenings were not fully completed, and although the instrument is not validated for use with female populations, female inmates were routinely screened. However, overall, in very few instances (less than 15), did screening officers note significant obstacles in completing the screening document. Overall, the screening tool was well-received by booking officers due to its ease of use.

The Brief Jail Mental Health Screen contains 8 yes or no questions that relate to the offender's current psychiatric symptoms and history of treatment for mental illness. In order to be "screened in" (referred for further mental health evaluation), the offender needed to answer "yes" to two items in questions 1-6 (relating to current symptoms), or "yes" on either question 7 or 8 (relating to current or past treatment).

In all, just short of 22% of inmates (n=292) were referred for further mental health evaluation during the study period, based on the results of the Screen. Please see Appendix C for additional information on the aggregated screening data.

Characteristics of Inmates Receiving Mental Health Services⁶

Data was collected between October 1, 2005 and March 31, 2006 on the types of offenders receiving mental health services at the jail through the LEC's contracted provider, Associated Clinic of Psychology (ACP).

Demographics

Of the 166 inmates served by ACP during the study period,

- 157 (96%) were male;
- 138 (83%) were white; 22 (13%) were black; 1 (1%) were American Indian/Alaskan Native; 1 (1%) were Multiracial. In 3% of cases, race was unknown.
- Average age of offenders treated was 32 years.

Diagnoses, Substance Use, and Services Received

During the study period, these 166 inmates made 538 visits to ACP staff. ACP employs a Licensed Psychologist, a Psychiatric Nurse, and a Psychiatrist to treat offenders at the Dakota County LEC. Typically, all offenders referred for services would be seen by the Psychologist, and some would then be referred to the other two professionals for evaluation for possible medication. Of the 538 visits:

- 326 (61%) of all visits were to the Psychologist;
- 101 (19%) were to the Psychiatric Nurse;
- 111 (21%) were to the Psychiatrist.

The largest number of offenders (30%; n=49) had only a single visit with an ACP provider. However, 114 offenders had multiple visits. While most offenders (91%; n=148) had 6 or fewer visits, the maximum number was 17 visits by the same offender.

⁴ Steadman, H.J. et al. (2005, July). Validation of the brief jail mental health screen. *Psychiatric Services* 56 (7): 816-822. [Available on-line: <http://ps.psychiatryonline.org>.]

⁵ Brief Jail Mental Health Screen, © 1995 Policy Research Associates, Inc. (See Appendix B for a copy.)

⁶ Thanks to Vickie Tholkes, Sandy Kerstetter, Brenda Kieffer, and Heidi Nygaard in Community Corrections for help with this database and with extensive data collection.

For the ACP portion of the data collection, information on diagnosis was also tracked. The number of offenders ACP staff identified as meeting state criteria for “seriously and persistently mentally ill” (SPMI) was small: 3%. The number identified as having concurrent substance abuse issues was also small: 4%. One or both of these numbers may be underreported, based on limited historical information available to the practitioner.

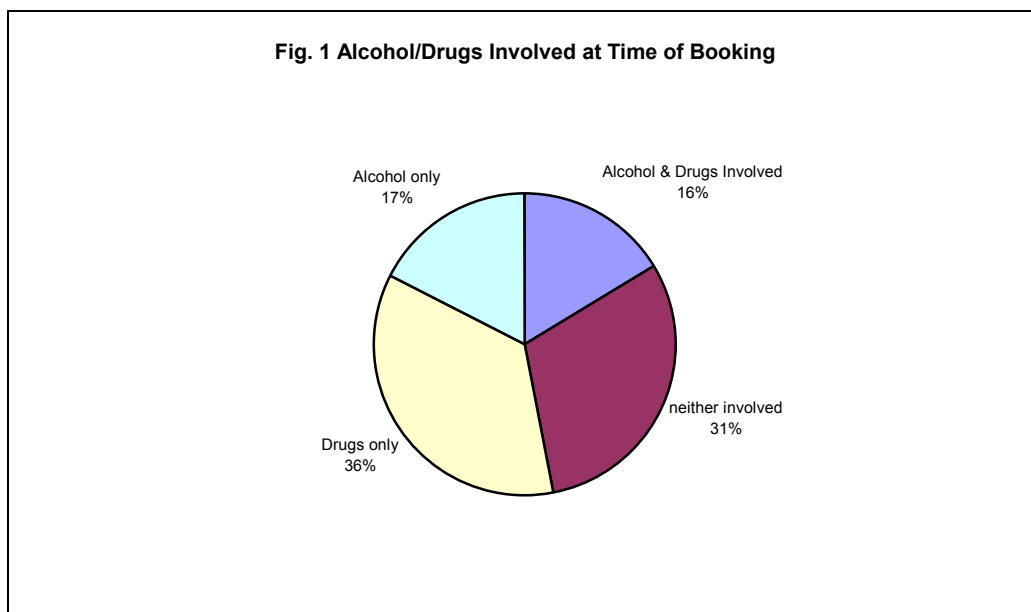
Of the 538 diagnosis records,⁷ there are a significant number of situations in which a diagnosis was not recorded:

- 21% of the time diagnosis was coded as “unknown”;
- 1% of diagnoses were deferred.

The vast majority of inmates presented with mood disorders (most often various types of Depression, other unspecified mood disorders, or Bipolar Disorder). A few were diagnosed with Schizophrenia or other problems. Of the 27 diagnosis codes used by ACP practitioners, the ones most often used include:

1. Major Depressive Disorder (19%);
2. Depressive Disorder, not otherwise specified (9%);
3. Schizophrenia (9%).
4. Bipolar I Disorder (8%);
5. Mood Disorder, not otherwise specified (6%);
6. Adjustment Disorder (5%);
7. ADHD (5%);
8. Amphetamine Dependence (3%);
9. PTSD; Bipolar, not otherwise specified; Dysthymia; Generalized Anxiety Disorder (all 2% each).

Over two-thirds of the offenders in the study (69%; n=115) had alcohol or drug involvement at the time of their arrest, as reflected by the formal charges against them.

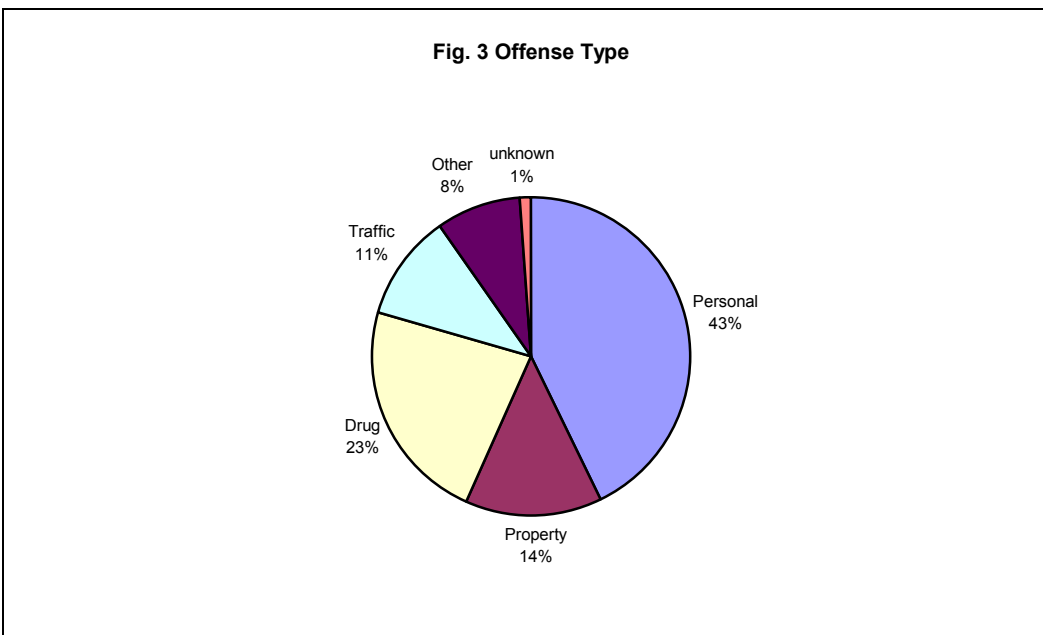
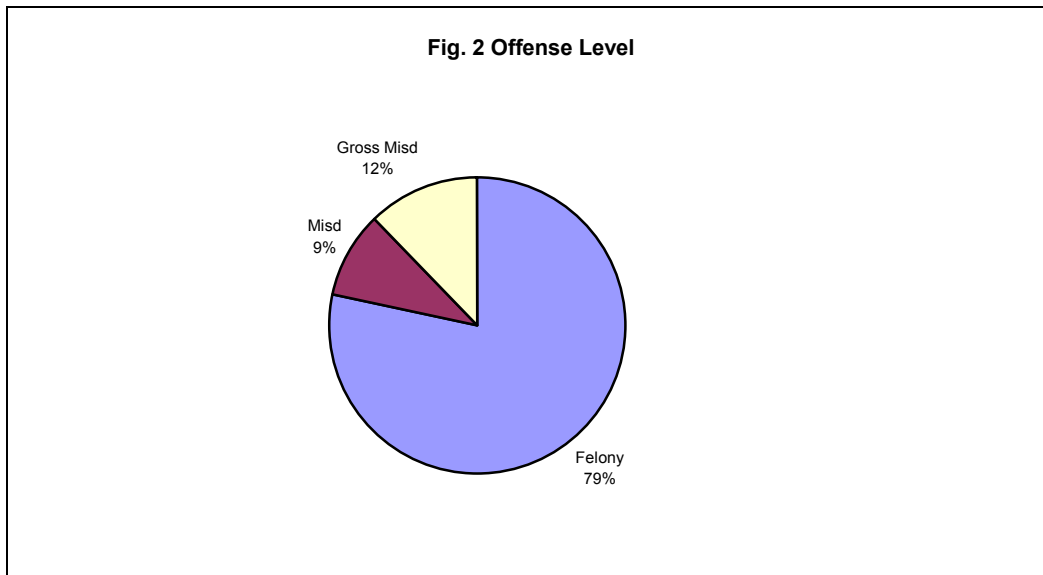


⁷ The data were not unduplicated, so clients with multiple visits are recorded multiple times.

Those with alcohol involvement made up only 17% of the population; drug involvement made up 36%; inmates involvement with alcohol and drugs at the time of booking made up 16% of the population (see Figure 1). The most common drugs identified were: methamphetamine (27%), marijuana (13%), and cocaine (12%).

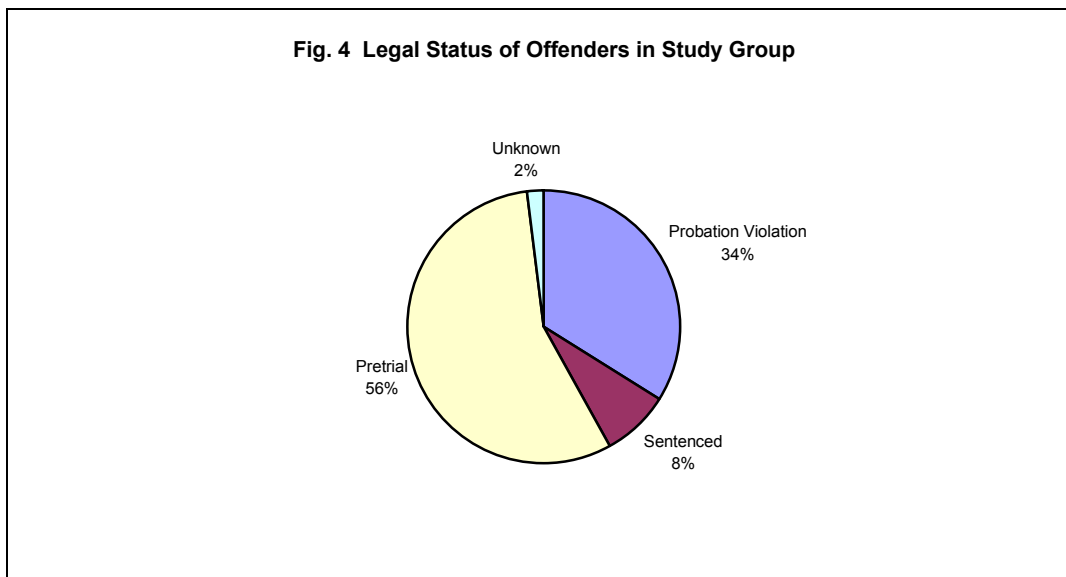
Current and Prior Bookings, Offenses, and Services

In terms of the current charges, nearly 8 out of 10 offenders in the study were booked on felonies (see Figure 2).⁸ The largest percentage of inmates had been booked on personal offenses (43%), followed by drug (23%), property (14%), and traffic (11%) crimes (see Figure 3).



⁸ Statistics relating to offense levels and types are based on the offender's most recent booking in the Dakota County Jail. In cases in which there was more than one charge, the most serious charge was recorded. These represent only charged offenses, not convictions.

Of the 166 offenders in the study, 34% were booked into jail on a probation violation. Over half (56%) of the offenders were on pretrial status, pending sentencing or other court proceedings that may include probation violation hearings. Sentenced offenders (8% of the study group) are serving court-ordered sentences (see Figure 4).



The offenders in the study also had a lengthy history of prior bookings and offenses. Among the 166 offenders, there were a total of 2,048 prior bookings (at Dakota County Jail or other Minnesota jails who report to the Statewide Supervision System.) The highest number of prior bookings was 52 per offender, while some offenders in the study had no prior bookings. The average number of prior bookings was 12. Of the study population, 19% went to prison following their most recent latest jail booking. In terms of prior offenses, there were 655 prior convictions among the study population; just less than a third (29%) of these were felonies.

In many cases among the study population, the possibility of the offender having a mental illness had been noted by the court at some time in the past. The court may order psychological evaluations, mental health treatment, or Rule 20⁹ evaluations, or pre-sentence investigations¹⁰ in cases in which they believe mental illness may be a factor. Among the 166 offenders, 21% had a previous history of a court-ordered psychological evaluation, 7% had court-ordered mental health treatment, 7% had a prior Rule 20 assessment, and 42% had a pre-sentence investigation at some time in the past.

Community Corrections Department staff collected data on LEC inmates who were also in the Community Corrections system either on probation, or accessing some level of service from the department at the time of their incarceration. The study concluded that of the 166

⁹ Competency to stand trial.

¹⁰ Pre-Sentence Investigations (PSI's) are ordered on misdemeanor and felony level offenses. They are ordered for all kinds of reasons; however, in general, they are ordered to investigate an offender's background and current situation, the current offense, and obtain victim impact/restitution information. PSI's aim to point out public safety issues, offender accountability and opportunity for positive change, risk/criminogenic factors, victim impact/restoration. Recommendations are then made for sentencing based on the above criteria as well as Minnesota Sentencing Guidelines and legislative mandates.

offenders, 80 offenders, or 48% were open to Community Corrections at the time of booking.

Conclusions About the Study Population

Overall, data on the offender population receiving treatment for mental illness while incarcerated provides the following snapshot:

- Most offenders in this category are white, male, and in their 30's.
- Most presented with mood disorders, and were seen multiple times by the mental health provider while incarcerated.
- Most (over two-thirds) had substance use that was at least serious enough to be related to the current charges that had brought them to the jail.
- The vast majority were charged with felonies, with personal and drug offenses being the most common types.
- Many of the offenders were well known to the system.
 - Most offenders in the group were awaiting trial, but about a third were booked on a probation violation, so were known to the system at the time of booking.
 - Almost half were open to Community Corrections at the time of booking.
 - In a number of cases, the possibility of mental illness among the offender had been noted by the court in the form of court orders for various evaluations and treatment.
 - Among the 166 offenders, there were 2,048 prior bookings and 655 prior convictions.

Background Research on Specialty Criminal Courts, Potential Costs and Benefits, and Model Options

Specialty "Problem Solving Courts" in General

Historically speaking, Mental Health Courts (MHCs) derive to some degree from the Drug Court movement, and are a variation of what is known as the "Problem-Solving Court" model. There are many models available for drug courts and mental health courts. Common features of MHCs include:

- Defendant participation is voluntary.
- Accept only persons with demonstrable mental illness likely to have contributed to involvement with criminal justice system.
- Objective is to prevent the jailing of mentally ill and/or securing their release from jail to appropriate services and support in the community.
- High priority for public safety concerns (usually focus on low-level offenders, exclusion of offenders with histories of violence).
- Expedite early intervention of offenders, immediately after arrest to a maximum of three weeks after arrest.
- Team approach including working more closely with mental health providers.
- More intensive accountability and monitoring of participant performance.
- Judge at the center of the treatment and supervision process.

Differences among MHC models include:

- Some are pre-adjudicatory and diversion oriented, participants are placed into treatment programs prior to the disposition of their charges (sometimes the charges are held in abeyance pending successful completion of the program).
- Concerning resolving criminal charges, some courts show offenders with no conviction on their records, some will show a conviction and, with successful completion of a program, some courts expunge the participant's criminal record.
- For noncompliant participants, some courts use short-term jail confinement, some terminate the offender from the program.

Potential Costs and Benefits

Relatively little outcome data currently exists on the efficacy of MHCs, despite the fact that since the late 1990s, these programs have become relatively widespread. A recent survey identified over 100 such projects nationwide. In addition to the lack of outcome data, projects vary widely in program characteristics, and it is not yet known which aspects produce the best outcomes.¹¹

Given the historical relationship between MHCs and Drug Courts, the high co-morbidity of chemical and mental health concerns and the similarity of the models, the more extensive data on Drug Court Outcomes may be a suitable substitute for the lack of MHC-specific data.

Established research on Drug Courts¹² has shown reductions in recidivism among participants and returns on investment in the 1:10 range. Drug Court evaluations also showed significant cost savings due to reductions in jail time served, the increased use of fees and fines as an alternative to incarceration, higher wages and related taxes paid, less welfare dependence, lower health care and mental health costs, and reductions in personal costs to the victim.

Early research¹³ on a Mental Health Court in King County (Seattle), Washington showed:

- A 75.9% decrease in the number of offenses and a 87.9% decrease in violent offenses committed at one year post graduation;
- A 90.8% decrease in jail time while in the program and at one year post graduation.

Model Options

As might be expected, a wide range of specific model options exist for MHCs, some of which are beginning to show promising outcomes, and some whose success has not been evaluated. Key decision points relating to variations among different MHC models are contained in Table 3.

In its extensive review of existing models, the Workgroup focused on models that had been evaluated, and showed promising outcomes. Appendix D shows a decision-making tree based on some of the key points in Table 3, and various research-validated Drug and Mental Health Court model options. The Workgroup suggests that should this project move forward, policymakers may wish to consider the key decision points enumerated in Table 3, as well as the decision-making model reflected in Appendix D when making a final decision on a model for implementation in Dakota County.

Staff also researched several models currently operating elsewhere in Minnesota. Notes about these programs, from Ramsey and Olmsted Counties, are contained in Appendix E.

¹¹ *Survey of Mental Health Courts* at <http://www.mentalhealthcourtsurvey.com/>, a joint project of the National Alliance of the Mentally Ill, TAPA Center for Jail Diversion, The National GAINS Center, and the Criminal Justice/Mental Health Consensus Project.

¹² C. West Huddleston III, Judge Karen Freeman-Wilson (ret.) and Donna L. Boone (2004, May). *Painting the Current Picture: A National Report Card on Drug Courts and Other Problem Solving Court Programs in the United States* 1 (1). Bureau of Justice Assistance, National Drug Court Institute, Executive Office of the US President.

¹³ John R. Neiswender (2004). *Executive Summary of Evaluation of Outcomes for King County Mental Health Court*, On-line: <http://www.metrokc.gov/kcdc/mhcsun32.pdf>.

Table 3. Key Decision Points Relative to Dakota County MHC Model

<i>DECISION CATEGORY</i>	<i>OPTIONS/SUBPOINTS</i>
<i>Overall Goal of Court</i>	<ul style="list-style-type: none"> • Increased public safety? • Increased access to treatment? • Improved quality of life? • More effective use of resources?
<i>Target Population</i>	<ul style="list-style-type: none"> • Mental or chemical health focus, or co-occurring? • If mentally ill, which diagnoses or SMI/SPMI? • If substance abuse, which substances?
<i>Level of Offense</i>	<ul style="list-style-type: none"> • Current charge misdemeanor only or felony-level? • Include violent offenders?
<i>Stage of Intervention</i>	<ul style="list-style-type: none"> • Pre-arrest • Post-arrest • Pre-Trial/Plea • Sentencing • Discharge
<i>Treatment Model</i>	<ul style="list-style-type: none"> • Referral sources? • Screening process? • Team members? • Use of social work and/or probation staff? • Use of pre-trial staff? • Case management model (e.g., ACT)? • Substance abuse models (e.g., Matrix or other)? • Availability of other services? • Consequences for noncompliance and terms of participation? • Specialty or non-specialty court?
<i>Operational Issues</i>	<ul style="list-style-type: none"> • Confidentiality practices; • Informed and voluntary choice; • Integration of treatment and community supports; • Sustainability.

Staff Perspectives on Serving Offenders with Mental/Chemical Health Needs

At the request of the Workgroup, Community Services Planning also conducted focus groups with staff from Community Corrections, Public Health, and Social Services Departments. The goal of these groups was to gain advice from front-line staff regarding existing needs, service gaps, and successful interventions for people with mental illness who are also involved in the criminal justice system.

Two focus group meetings were held in March 2006 at the Dakota County Northern and Western Service Centers, respectively. A mixture of Probation Officers, Social Workers, and Public Health Nurses was invited to each meeting.

Key findings from the focus groups include the following:

1. Mixed report on the current system. Overall, the groups report that Dakota County is currently having mixed success working with offenders who also have mental illness. This is acknowledged as a very challenging population to work with. In spite

of this observation, some interventions such as services at the Jail, Crisis Response Unit, and case management are viewed as fairly successful. Lack of consistent access to intensive and ongoing services is viewed as problematic.

2. Consensus on the qualities of a more effective service delivery system. Focus group participants emphasized the importance of improving collaboration across various service delivery systems, improving continuity of care for offenders with mental illness, and evolving a more intensive model for working with this population. These qualities are seen as key elements in any new intervention design.
3. Effectiveness of services if accessible. Among focus group participants, there was a general sense of optimism about the opportunities for successful intervention with this population, so long as the individual can access needed services. This viewpoint is consistent with the current understanding of mental illness as a highly treatable, biologically-based brain disorder. Lack of adequate resources to serve all in need and difficulty accessing existing services was cited repeatedly as a barrier in need of resolution.
4. Support for new interventions. Partnered with the overall belief in the potential for more effectively serving this population is an enthusiasm for several of the intervention models described. The group participants liked the intensive community intervention model and the Probation Officer/Social Worker intensive case management model entertained at the County level. The groups also appeared to reach consensus around the need to focus on mental illness (broadly defined), the desire not to exclude felons from participation (including those with violent histories), and the need to improve consistency among team members working with this population. These consensus items appear to be congruent with the existing County Board goal relating to the implementation of a Mental Health Court.

Next Steps

As noted, the project is currently on hold due to the current hiring freeze. Should the freeze be lifted, the project could restart with a revised timeline by convening the Steering Committee to review the results of the above data collection and research efforts, using these to develop recommendations on the target population, model, and a work plan going forward.

Appendix A
Timeline for Addressing Needs of Offenders with Mental/Chemical Health Concerns¹⁴

STEP	TIMELINE	TASK	WHO IS INVOLVED?
1	Summer of 2005	Plan for collection of data on offenders to help refine target population.	Workgroup convened by CC including: CC, Sheriff, CSP, SS, and PH staff.
2	August and September, 2005	Discuss progress and next steps with Criminal Justice System stakeholders.	Representatives from workgroup meet with key stakeholders: CJC, County Attorney, Sheriff, etc.
3	September-December, 2005	Begin data collection process: <ul style="list-style-type: none"> • Screening of offenders at LEC; • Recording of ACP data. 	Workgroup members plus Jail and CC staff.
4	September-December, 2005	Research model and funding options.	CSP.
5	January 2006 (pending approval of budget request)	<ul style="list-style-type: none"> • Hire SS and CC staff to begin serving specialized caseload of offenders with mental and/or chemical health issues. 	SS, CC.
6	March, 2006	Convene Steering Committee: <ul style="list-style-type: none"> • Review results of data collection and research efforts; and • Develop recommendations to CJC and County Board on target population, model, and workplan. 	Convened by CC, Steering Committee to include: <ul style="list-style-type: none"> • County Attorney, • Sheriff, • Judge(s), • Public Defender.
7	April and May, 2006	Meet with CJC and County Board to provide policy direction to project: Decide on target population, model, workplan.	CC, CSP.
8	Summer 2006	Re-convene Steering Committee to: <ul style="list-style-type: none"> • Operationalize work plan, • Review resources and advise direction on funding opportunities. 	CC convenes same group as above.
9	Summer/Fall 2006 (pending Steering Committee decision)	Facilitate process to seek internal/external funding.	CC and/or CSP.
10	January 2007	Begin implementation of specialized court model.	Staff from various departments.

¹⁴ ACP=Associated Clinic of Psychology; CC=Community Corrections; CJC=Criminal Justice Council; CSP=Community Services Planning; LEC=Law Enforcement Center; PH=Public Health; SS=Social Services.

Appendix B

BRIEF JAIL MENTAL HEALTH SCREEN

Section 1

Name: _____ <small>First MI Last</small>	Detainee #: _____	Date: ____/____/____	Time: _____ AM PM
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Section 2

Questions	No	Yes	General Comments
1. Do you <i>currently</i> believe that someone can control your mind by putting thoughts into your head or taking thoughts out of your head?			
2. Do you <i>currently</i> feel that other people know your thoughts and can read your mind?			
3. Have you <i>currently</i> lost or gained as much as two pounds a week for several weeks without even trying?			
4. Have you or your family or friends noticed that you are <i>currently</i> much more active than you usually are?			
5. Do you <i>currently</i> feel like you have to talk or move more slowly than you usually do?			
6. Have there <i>currently</i> been a few weeks when you felt like you were useless or sinful?			
7. Are you <i>currently</i> taking any medication prescribed for you by a physician for any emotional or mental health problems?			
8. Have you <u>ever</u> been in a hospital for emotional or mental health problems?			

Section 3 (Optional)

Officer's Comments/Impressions (check <i>all</i> that apply):		
<input type="checkbox"/> Language barrier	<input type="checkbox"/> Under the influence of drugs/alcohol	<input type="checkbox"/> Non-cooperative
<input type="checkbox"/> Difficulty understanding questions <input type="checkbox"/> Other, specify: _____		

Referral Instructions: This detainee should be referred for further mental health evaluation if he/she answered:

- YES to item 7; OR
- YES to item 8; OR
- YES to at least 2 of items 1 through 6; OR
- If you feel it is necessary for any other reason

☐ Not Referred

☐ Referred on ____/____/____ to _____

Person completing screen _____

INSTRUCTIONS ON REVERSE

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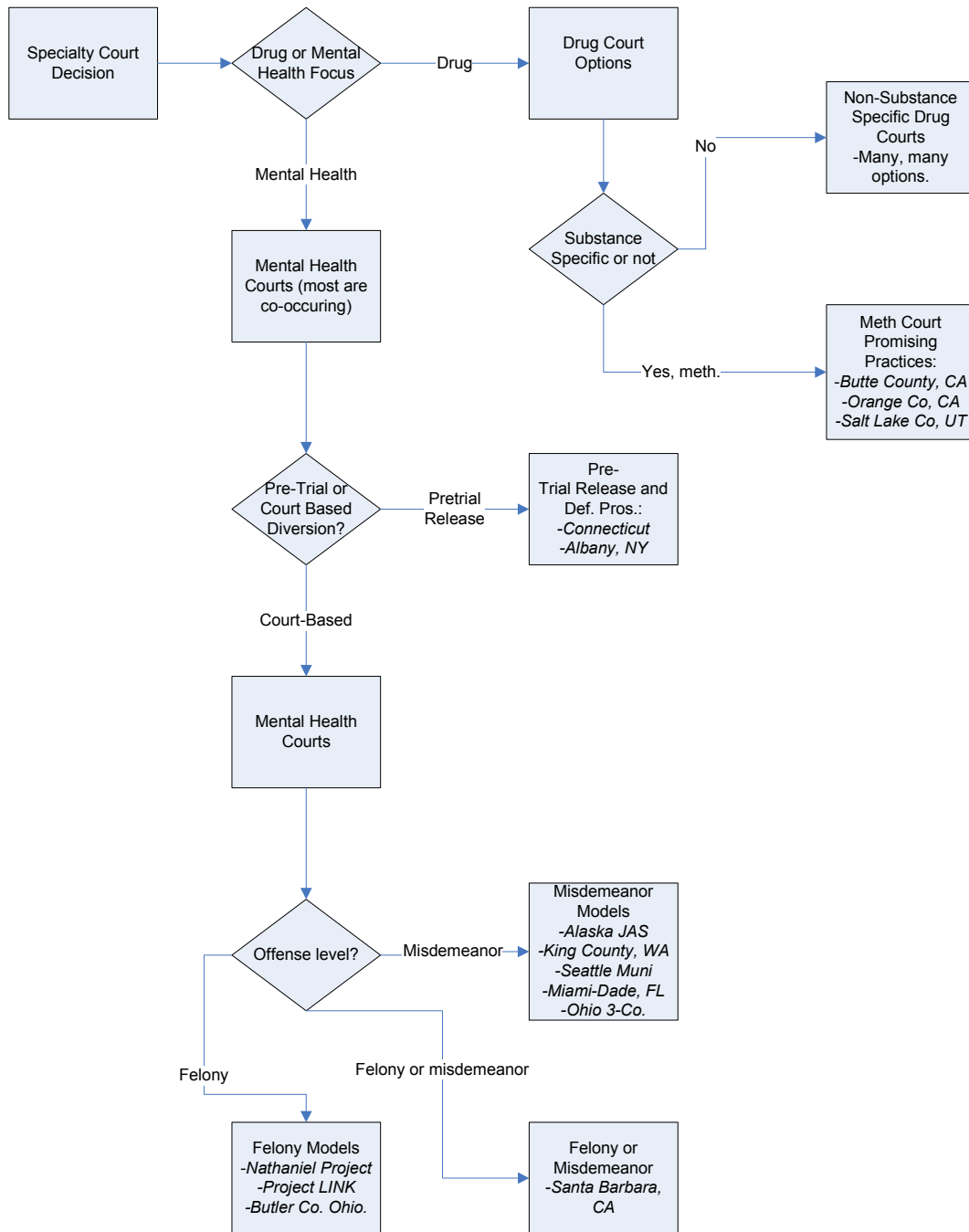
Appendix C
Final Data Report – Jail Brief Mental Health Screening

In order to be “screened in,” (referred for further mental health evaluation), the offender needed to answer “yes” to two items in questions 1-6, “yes” or EITHER question 7 or 8.

QUESTION	NUMBER OF ALL INMATES (PERCENT) RESPONDING “YES”	PERCENT OF SCREENED IN INMATES RESPONDING “YES”
1. Do you <i>currently</i> believe that someone can control your mind by putting thoughts into your head or taking thoughts out of your head?	36 (2.7%)	12.3%
2. Do you <i>currently</i> feel that other people know your thoughts and can read your mind?	33 (2.5%)	11.3%
3. Have you <i>currently</i> lost or gained as much as two pounds a week for several weeks without even trying?	112 (8.4%)	38.4%
4. Have you or your family or friends noticed that you are <i>currently</i> much more active than you usually are?	61 (4.6%)	20.9%
5. Do you <i>currently</i> feel like you have to talk or move more slowly than you usually do?	67 (5.0%)	22.9%
6. Have there <i>currently</i> been a few weeks when you felt like you were useless or sinful?	134 (10.1%)	45.9%
7. Are you <i>currently</i> taking any medication prescribed for you by a physician for any emotional or mental health problems?	201 (15.1%)	68.8%
8. Have you <u>ever</u> been in a hospital for emotional or mental health problems?	152 (11.4%)	52.1%
Total number (percent) “screened in”:	292 (21.97%)	N/A

Appendix D

Decision Tree for Specialty Court Models December 8, 2005



Appendix E

Notes on Some Other Mental Health Court/Jail Diversion Models in Minnesota

RAMSEY COUNTY

Telephone conversation with Jessica McConaughy, St. Paul City Attorney's Office, 651-266-8750:

- The Ramsey County Attorney's Office is really not involved in their program at this point, because the Court is not dealing with any felony offenders.
- Ramsey County Community Human Services (RCCHS) does provide case management support.
- Their model is really part of the whole spectrum of problem-solving court models in Ramsey, and it is operated much the same way as their DWI, Drug Court and Juvenile Drug Courts.
- Mental Health Court calendar is always held Monday afternoons, 1:30.
- Monday mornings are reserved for a team staffing of MHC cases. Team includes the following professionals:
 - 2 judges (1 and 1 backup, sole ones working with this court);
 - Prosecutor from City Attorney's Office (Jessica);
 - Public Defender representative – always on the team even if the offender has private representation. Private attorneys can appear in front of the team at their request;
 - Case manager from RCCHS;
 - MHC Coordinator (position is currently vacant);
 - Project Remand are part of the team -- participates in diversion cases.
- Formal eligibility criteria include the following:
 - Must be diagnosed as having serious mental illness. (All offenders are screened at the Law Enforcement Center. The case manager follows up by performing a functional & diagnostic assessment.)
 - Ramsey County resident;
 - Must be a repeat offender or "frequent flier;"
 - Must not have any violent offenses (current or history);
 - Usually may not have a history of felony offense, although this is not an automatic disqualifier.
- Their process goes something like this:
 - Jessica states there is a huge need for this type of court. They get a lot of referrals. The team decides which cases to take, and try to limit the caseload to 25. They are currently exceeding this number.
 - Participation is voluntary.
 - They have 2 "tracks": 1.) "diversion," in which case there is no plea; and 2.) "probation" in which the offender pleads guilty and is sentenced to probation, with conditions for complying with MHC recommendations (treatment, etc.)
 - Person comes into court initially once a week while services and meds are being set up, and until the team gets a sense of "who they are," or until they begin to see some compliance with the plan.
 - They have a list of incentives and sanctions they can use, but haven't had to much.

- The case manager works with the person to set up services. Typically stable housing is a huge need in addition to others. If the person comes in with a case already open to another RCCHS case manager, the MHC case manager does not take over the case, but works along with the existing person.
 - They acknowledge co-occurring chemical health concerns are common in this population. Chemical health evaluation is part of the assessment process. In order for the person to be eligible for participation, MI -- not CD -- must be the primary presenting problem.
- How's it working?
 - There is no formal evaluation ongoing currently, they anticipate beginning when the new Coordinator is hired.
 - Jessica is a self-described "law and order" type who really believes in this program. She describes it as a "prevention/intervention success story."
 - Jessica states that this program takes an intensive up-front investment of resources, but (based on anecdotal evidence) she believes the program is very successful at avoiding new offenses. She is very comfortable with the level of accountability and public safety provided by the program.
 - Jessica questions how well this type of program would work with felons.
 - She admits they have a very difficult time successfully serving people involved in prostitution. They haven't closed off eligibility for this population of offenders at this time.
 - She believes problem-solving courts are the "wave of the future" and is excited to be on board.
- Thoughts on our model ideas:
 - Jessica questions how well this type of program would work with felons.
 - Jessica was very enthusiastic regarding the Dakota County idea for having a SW/PO team, as she feels lack of a PO on their team has been an issue and the 2 departments could improve collaboration.

OLMSTED COUNTY

- Telephone conversation with Carla Hammand, Olmsted County Jail, 507-529-4695:
- Olmsted County has been operating this program since 1998. They began with .2 FTE (not located at the Jail), grew to .5 FTE and physically relocated staff to the Jail site in 2001. Now they have 1.5 FTE situated the Jail.
- This program has two main subparts: Jail Diversion (court involvement) and Discharge Planning. Carla used to do both, but now she does Diversion in her .5 time and the other staff person does Discharge Planning full time.
- This is a very small-scale program serving only 5-10 people a year in Jail Diversion.
- Carla has been with the program for 5 years. She has made a lot of effort, particularly initially to introduce the program to the judiciary and CAO, to gain acceptance of their efforts.
- She has found over time that it is important for her credibility in interacting with the bench and CAO to be extremely consistent in her evaluation of various situations. She typically understands the CAO wants some consequences for the offender other than release, and that judges like to have several options to consider (A, B, or C) rather than a single recommendation.

- Some notes on eligibility:
 - In the Jail Diversion program, they accept nonviolent offenders only – mostly misdemeanors and gross misdemeanors.
 - Carla believes most of their clients fall into the “thought disorder” category (e.g., schizophrenia vs. major depression).
 - In excess of 50% of Diversion clients do not want her help, at least initially, because they are so ill, often very paranoid. Their ability to involuntarily administer psychotropic medications helps stabilize people while in Jail.
 - She works hard to sort out “real” mental illness from malingering.
 - Their first priority is to serve SPMI, then SMI.
 - They do accept individuals with co-occurring substance abuse issues, but Axis I mental illness must be the primary presenting condition. They will not accept individuals with drug or alcohol-induced psychosis or those with primary substance abuse.
- The process in Olmsted is quite informal:
 - The referral usually comes from the Jail booking officer based on a mental health screening. Often the officer will identify the person based on their inability/unwillingness to cooperate with the screening just as often as the results. If the person is missed in the screening process, often they will be identified by Jail nursing staff. Judges sometimes make the referrals also.
 - Carla just shows up at the criminal court for the arraignment calendar based on referrals – there is no separate mental health calendar or court. Carla would love to see a specialized MHC in Olmsted County.
 - Carla lets court officers, CA know who she is there for and asks that they be “held until appropriate services can be put in place.” She also contacts the PD ahead of time to alert them to a client coming through. She works with PD Dispo. Advisor if it’s a felony case.
 - Although most of the work is done off the arraignment calendar, for felons the involvement usually waits until later in the court process.
 - She works to advocate for the client in cases in which she feels its appropriate/CAO will go for diversion, in which case the person is released but “must follow recommendations of the Social Services Department.”
 - Carla stated they also use commitment quite often, and Rule 20s, particularly with felony offenders.
 - Sometimes the goal of Carla’s intervention is to advocate for a particular outcome. Most often times, she is providing information to the court on the impact of the mental illness, the person’s history of mental illness, and community resources.
 - She does a lot of research/calling around to research offenders mental health history prior to court. She finds other counties/providers are quite flexible in releasing information due to the emergent need.
 - Carla refers the individual to their in-house psychologist or psych nurse for diagnostic assessments or for a letter in support of commitment. She emphasized several times how important this aspect is to her work.
 - Clients receive Discharge Planning from another Social Worker in the Jail.
 - Internal Social Worker does intake and staffs the case;
 - She provides Rule 25 services while in Jail and at discharge;
 - She does front-end case planning, and then transfers case to ongoing worker or ACT team, as appropriate;

- Some offenders do lack self-care ability (I presume this means there could be Adult Protection involvement on the basis of self-neglect also).
- Internal Social Worker also gets MA set up, as well as housing.
- Internal Nursing staff set up meds and follow-up psychiatric appointments.
- If offenders are released prior to Discharge Planning opportunity, they receive a list of community resources and can meet with Social Worker when in the community.
- Carla emphasized the difficulty of doing discharge planning without release data (date/conditions unknown).
- If the person is not appropriate for commitment, they build treatment recommendations into the release plan. This is tracked by probation, and P.O.s will use jail time as a way to induce compliance.
- Teaming between Corrections and Social Services is improved, but could be even better.
- Most offenders who receive services do not re-offend.
- Carla also does some work training law enforcement on pre-court diversion strategies (i.e., you can ticket/arrest someone, but if they have florid MI, take them to ER instead of jail).